STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Insurance Company First Quarter 2018 and Second Quarter 2018 Large Group HMO Rate Filing	)))))	GMCB-012-17rr SERFF No.: MVPH-131213366

DECISION AND ORDER

Introduction

Vermont law requires that health insurers submit major medical rate filings to the Green Mountain Care Board which shall approve, modify, or disapprove the filing within 90 calendar days of its receipt. 8 V.S.A. § 4062(a)(2)(A). On review, the Board must determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. § 4062(a)(3).

Procedural History

On September 29, 2017, MVP Health Plan, Inc. (MVPHP) submitted its First Quarter 2018 (1Q18) and Second Quarter 2018 (2Q18) Large Group HMO Rate Filing to the Board via the System for Electronic Rate and Form Filing (SERFF).[1] The Office of the Health Care Advocate declined to enter an appearance as a party to this filing.

On November 6, 2017, the Board posted to the web the Department of Financial Regulation's (DFR) analysis regarding the filing's impact on the insurer's solvency. On November 28, 2017, the Board posted to the web an actuarial memorandum provided by its contract actuaries, Lewis & Ellis (L&E). The Board received no public comment. Pursuant to GMCB Rule 2.000, § 2.309(a)(1), the carrier waived the hearing and filed a memorandum in lieu thereof.

Findings of Fact

1. MVPHP is a non-profit health insurer domiciled in New York State and licensed as a health maintenance organization (HMO) in New York and Vermont. The carrier is a subsidiary of MVP Health Care, Inc., a New York corporation that transacts health insurance business through a variety of for-profit and not-for-profit subsidiaries, and provides health insurance coverage to individuals and employers in the small and large group markets in New York and Vermont.

2. The filing includes proposed rates and demonstrates premium development for MVPHP's large group HMO product for 1Q18 and 2Q18. Although there are currently no members enrolled in these plans, the carrier expects to migrate approximately 1,995 members from its PPO block of business to this block beginning with April 1, 2018 policy renewals.

[1] The contents of the SERFF filing and all documents referenced in this Decision and Order can be found at http://ratereview.vermont.gov/MVPH-131213366.

3. Overall, the HMO plans have more generous benefits and lower copays than the PPO plans they will replace. High-deductible health plans[2] and other leaner benefit designs will no longer be available to migrating policyholders. Otherwise, there are no network or prior authorization differences between the two lines of business.

4. In anticipation of moving members from its PPO to its HMO business, MVPHP submitted proposed rates for a fully manual rated[3] group and a fully experience rated group.[4] A group between 50 and 1,000 members would be partially credible and receive a blend of the two rate changes, while a group with over 1,000 members would be fully experience rated.

5. For a fully manually rated group, MVPHP proposes a 6.1% average annual rate decrease for members renewing in 1Q18 and 2Q18, with a quarterly decrease of 8.6% in 1Q18, and an increase of 1.4% in 2Q18.

6. For a fully experience rated group, MVPHP proposes a 6.0% average annual rate increase for members renewing in 1Q18, and a 5.8% annual rate increase for members renewing in 2Q18, with a quarterly increase of 1.5% in 1Q18 and 1.2% in 2Q18.

7. MVPHP used its large group PPO claims data as the base experience period. The carrier modified its rating methodology to use current snapshots of enrollment distribution by age and tier to adjust for changes in enrolled population that have occurred since the end of the experience period. These factors are 0.1% lower than those previously approved due to changes in enrollment mix.

8. Taking into consideration the Board's 2018 hospital budget orders, the carrier proposes a paid medical trend of 3.3%, which assumes a 0.6% increase in utilization. MVPHP proposes a paid pharmacy trend of 12.8%, weighted using data from the previous PPO filing.

9. MVPHP assumes a general administrative expense load of 9.7% and proposes a 2.0% contribution to reserve (CTR).[5] As a small portion of MVPHP's Vermont members utilize New York hospitals, the proposed administrative expense load includes approximately $1 per member per month (PMPM) to reflect the New York Health Care Reform Act (HCRA) surcharge, which is applicable to all claims processed by hospitals in New York regardless of whether the patient is a New York resident.

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[2] A high-deductible health plan is a plan with a higher annual deductible and lower annual premium than typical health plans.

[3] A manual rate is a baseline rate structure that a carrier will blend with a specific group's claims experience to produce the group's actual rates. Its weight in calculating rates for a specific group will vary according to the group's size and actuarial credibility.

[4] As no members are currently enrolled in this block, the rates provided by the carrier are a theoretical representation of the rate increase that would be experience if a member was enrolled.

[5] "Contribution to reserve" funds are set aside or "reserved" solely to cover unanticipated future claims.

10. MVPHP anticipates that the proposed rates will generate a traditional loss ratio of 84.2%, and a federal loss ratio of 86.5%.[6] As in other recent filings, *see, e.g.*, Docket no. GMCB-011-17rr, the carrier treats the billback authorized by 18 V.S.A. § 9374(h) as a claims expense.

11. DFR assessed the impact of the proposed filing on the carrier's solvency. Noting that it is not MVPHP's primary regulator, that New York State regulators have expressed no concerns about the carrier's solvency, and that all of MVP's health operations in Vermont accounted for approximately 2.2% of its total premiums written in 2016, the Department determined that the carrier's Vermont operations pose little threat to the carrier's solvency. DFR further opined that the rates as filed will promote MVPHP's solvency absent a finding by L&E that they are inadequate.

12. On review, L&E recommends the Board approve the rates as proposed, opining that the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory.

13. L&E makes no specific recommendation concerning MVPHP's proposed 2.0% CTR, noting that the Board has reduced the contribution in past filings from 2.0% to 1.0%, and states that the Board should defer to DFR's solvency analysis when making changes to the proposed CTR.

14. While L&E does not agree that the costs of the billback should be treated as a claims expense, the proposed rates are compliant with all applicable loss ratio requirements regardless of how the billback is reported.

Standard of Review

The Board reviews rate filings to ensure that a proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). Although the first several terms—excessive, inadequate, or unfairly discriminatory—are defined actuarial standards, other standards by which the Board reviews rate filings are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16. The Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401.

In arriving at its decision, the Board must consider the Department's analysis and opinion of the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2)(B), (3). The Board must also consider any public comments received on a rate filing. 8 V.S.A. § 4062(c)(2)(B); GMCB Rule 2.000, § 2.201. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c).

[6] As opposed to calculation of the traditional loss ratio, calculation of the federal minimum loss ratio under the ACA allows insurers to adjust for quality improvement activities and expenditures on taxes, licensing and regulatory fees.

Conclusions of Law

We first address the carrier's plan to move members from its PPO book of business to plans represented in this filing. On review, we are satisfied that members migrating to the HMO products will not be adversely affected overall, and should experience comparable rates for similar plan designs, notwithstanding the unavailability of certain plan choices.

We next agree with and adopt our actuary's opinion that the proposed medical and pharmacy trends and other adjustments are appropriate and actuarially reasonable, and note that the carrier incorporated the results of our hospital budget review process within its calculations. Moreover, the resulting medical trend of 3.3% falls below the medical trend we approved in other recent MVP filings. *See, e.g.*, Docket nos. 011-17rr (1Q/2Q18 Large Group PPO); 010-17rr (1Q/2Q18 Grandfathered Small Group); 007-17rr (2018 Vermont Health Connect).

Turning to administrative expenses, we agree with and adopt our actuary's opinion that MVPHP's proposed 9.7% administrative expense figure accurately reflects the costs associated with administrating claims for this relatively small block of business. Again, however, we note that this figure may be artificially low because the carrier continues to exclude the so-called billback amounts from its administrative expense calculation, including them instead within their claims. *See, e.g.*, Docket no. 010-17rr (1Q/2Q18 Small Group Filing) at ¶ 9. While we recognize that the carrier's mischaracterization of these expenses does not place it out of compliance with federal MLR requirements in this filing, in future filings, MVPHP must include such amounts within its administrative expenses, consistent with the treatment of other taxes and fees imposed by the state and federal governments.

We also conclude that the 2.0% CTR proposed by MVPHP is reasonable and appropriate to stabilize pricing for this relatively small population. Although we have at times reduced the proposed CTR to make rates more affordable for policyholders, the current uncertainty in the commercial insurance market cautions in favor of approving the CTR as proposed. In doing so, we have considered DFR's analysis and opinion that the rates as filed will promote MVPHP's solvency.

In conclusion, we find that the proposed rates are neither excessive nor inadequate, are safely within the range of actuarial reasonableness, and strike an appropriate balance between fairness and equity to policyholders, and rate stability and insurer solvency.

Order

For the reasons discussed above, the Board accepts MVPHP's filing without modification and approves: 1) a decrease of 6.1% in the average annual manual rate for 1Q18 and 2Q18 renewals, and 2) average annual rate increases of 6.0% and 5.8% for 1Q18 and 2Q18, respectively, for fully experienced groups.

SO ORDERED.

Dated: December 28, 2017 at Montpelier, Vermont

s/ Kevin Mullin, Chair	)	
	)	
s/ Jessica Holmes	)	GREEN MOUNTAIN
	)	CARE BOARD
s/ Robin Lunge	)	OF VERMONT
	)	
s/ Thomas Pelham	)	
	)	
s/ Maureen Usifer	)	

Filed: December 28, 2017

Attest: s/ Erin Collier, Administrative Services Coordinator
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (E-mail address: agatha.kessler@vermont.gov). Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.